DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES	, ,		PRINTED: 07/11/201			
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	454	~ 8/24//3	FORM APPROVE			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		445458	B. WING		07/09/2042			
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
FOUR C	AKS HEALTH CARE (1	1101 PERSIMMON RIDGE RD JONESBOROUGH, TN 37659				
(X4) ID PREFIX TAG	{EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION			
K 000	INITIAL COMMENT	rs .	K 000					
K 038 SS=D	42 CFR 483.70(a) K3 BUILDING: 1-story Type V(111), unprotected, Combustible construction with a complete automatic sprinkler system. K6 PLAN APPROVAL: 1981 K7 SURVEY UNDER: 2000 EXISTING K8 84-bed SNF/NF NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1		K 038	K 038 1. Magnetically locked door by room #1 was repaired by Maintenance Director on July 8, 2013 and released correctly when activated by fire alarm. 2. On July 8, 2013 Maintenance Director audited all other magnetically locked doors to ensure magnetically lock doors release when the fire alarm is activated. 3. Administrator inserviced Maintenance Director on July 8, 2013 to ensure all magnetically locked doors release during fire drills. 4. An audit conducted by Maintenance Director, Staff Development Coordinator or Shift				
SS≕F	failed to ensure all n released upon fire a Findings include: Observation and inte Director, on July 8, 2 one (1) of eight (8) n room #1, failed to relactivated. The delay and all staff interview the door. This finding was verification and acknowledges and acknowledges and acknowledges. Administrator during 8, 2013. NFPA 101 LIFE SAF	erview with the Maintenance 2013 at 1:55 p.m. confirmed nagnetically locked doors, by lease when the fire alarmed ed egress functioned properly wed knew the code to unlock ified by the Maintenance towledged by the the exit conference on July ETY CODE STANDARD required for life safety is maintained in accordance	K 052	Supervisor on all magnetically for automatic release during fire completed weekly for one more monthly for two months and/or compliance. The results of the apresented by the Maintenance D Quality Assurance/Performance Committee. The Assurance/Performance Committee consists of at Administrator, Director of Nursi Director of Nursing, Admissi Housekeeping Director, Director, Food Services Director, Social Services Director Services Director and the Medical Materials.	locked doors drills will be inth and then r until 100% audits will be Director to the Improvement Quality Improvement least the ing, Assistant ion Director, Maintenance stor, Activity ctor, Therapy al Director.			
BORATORY	PIRECTOR'S OR PROVIDE	RUSUPPLIER REPRESENTATIVE'S SIGNA	,	TITLE	(X6) DATE			
$-\Delta I$	11/1 / MU//	WINDIN (SC	VYUN	ustrator 7	1-22/13			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF GORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445458 B. WING NAME OF PROVIDER OR SUPPLIER 07/08/2013 STREET ADDRESS, CITY, STATE, ZIP CODE FOUR OAKS HEALTH CARE CENTER 1101 PERSIMMON RIDGE RD JONESBOROUGH, TN 37659 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) K 052 Continued From page 1 K 052 2. East TN Fire Alarm will audit all fire alarm with NFPA 70 National Electrical Code and NFPA strobes to insure they are synchronized when 72. The system has an approved maintenance rework is complete. and testing program complying with applicable 3. On July 8, 2013 Administrator inserviced requirements of NFPA 70 and 72. 9.6.1.4 Maintenance Director on fire alarm strobe light synchronization. Maintenance Director will include fire alarm strobe synchronization in PM schedule check. 4. An audit by Maintenance Director of strobe light synchronization will be conducted upon completion and monthly for three months and/or until 100% compliance. The results of the audits will be presented by the Maintenance Director This STANDARD is not met as evidenced by: to the Quality Assurance/Performance Based on observation and interview, it was Improvement Committee. determined the facility failed to ensure fire alarm The Quality Assurance/Performance strobes were synchronized where more than two improvement Committee consists of at least the were in the field of view. Administrator, Director of Nursing, Assistant The findings include: Director of Nursing, Admission Director, Observation and interview with the Maintenance Housekeeping Director, on July 8, 2013 at 2:10 p.m., confirmed Director. Maintenance Director, Food Service Director, Activity fire alarm strobes in the facility did not flash in Director, Social Services Director, Therapy synchronization. Services Director and the Medical Director. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 8, 2013, NFPA 101 LIFE SAFETY CODE STANDARD K 066 K 066 K 066 \$\$≒D On July 7, 2013 Maintenance Director Smoking regulations are adopted and include no removed noncombustible trashcap with less than the following provisions: self-closing from designated smoking area. On July 18, 2013 Maintenance (1) Smoking is prohibited in any room, ward, or Director placed metal container with compartment where flammable liquids, self-closing cover in designated smoking combustible gases, or oxygen is used or stored атеа. and in any other hazardous location, and such Facility has only one designated smoking area is posted with signs that read NO SMOKING area; no other areas involved. or with the international symbol for no smoking.

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		& MEDICAID SERVICES				MB NO.	. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		445458	B. WING			07/	08/2013
NAME OF PROVIDER OR SUPPLIER FOUR OAKS HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PERSIMMON RIDGE RD JONESBOROUGH, TN 37659		07/08/2013	
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	(2) Smoking by pate responsible is probled responsible is probled in provided sign are provided permitted. (4) Metal containers devices into which a readily available to permitted. (5) This STANDARD is Based on observation and into Director, on July 8, 2 the smoking area has This finding was verification.	continued From page 2 Smoking by patients classified as not esponsible is prohibited, except when under rect supervision. An audit by Main be conducted to a with self-closing cover eadily available to all areas where smoking is ermitted. 19.7.4 Assurance/Perform Committee. Assurance/Perform Committee		An audit by Maintenance Director be conducted to ensure metal conviting self-closing lid is present smoking area weekly for one monther monthly for three months until 100% compliance. The rest the audits will be presented by Maintenance Director to the Committee. The Committee. The Assurance/Performance Improve Committee consists of at least Administrator, Director of No Assistant Director of Norsing, Administrator, Admini	se Director istrator to self-closing d smoking rector will it container present in month and this and/or results of d by the e Quality provement Quality provement least the Nursing, Admission Director, it Services ; Social Services		
K 067 SS=F	8, 2013. NFPA 101 LIFE SAF Heating, ventilating, with the provisions of in accordance with the	the exit conference on July ETY CODE STANDARD and air conditioning comply f section 9,2 and are installed	K 06	7 K. 1.		e propo ire dan maintens	osals Oper

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		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		E CONSTRUCTION D1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		445458	B. WING	G		07/	07/20/20	
NAME OF PROVIDER OR SUPPLIER FOUR OAKS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PERSIMMON RIDGE RD					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	 -	JONESBOROUGH, TN 37659				
PRÉFIX TAG	CACO DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	100	(X5) COMPLETION DATE	
K 067	This STANDARD is Based on interview determined fire dam least every 4 years, applicable) shall be be operated to verify latch, if provided, sh parts shall be lubrica. The findings include Record review and i Maintenance Director, m. confirmed the fife-year required maintenance was verify supervisor and acknowledge.	and met as evidenced by: and record review, it was apers were not maintained at fusible links (where removed; all dampers shall that they fully close; the all be checked; and moving ated as necessary. Interview with the or on July 8, 2013 at 10:00 actility falled to perform the atenance to fire dampers.	K	3. On July 8, 2013 Administrator inservices Maintenance Director on fire damper inspection. Maintenance Director will verifie damper maintenance is completed and with include on PM schedule. 4. An audit to ensure fire damper maintenance inspection will be conducted by Maintenance Director. The results of the audit will be presented by the Maintenance Director to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Assistant Director of Nursing, Admission Director Housekceping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.			mper erify will ance ance l be o the ment sality ment the stant actor, octor,	
	8, 2013, NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the commercial cooking stove and deep fryer were not separated by at least 16 inches. The findings include: Observation and interview with the Maintenance Director, on July 8, 2013 at 8:45 a.m. confirmed the deep fryer and gas stovetop were 9-inches apart. This finding was verified by the Maintenance Supervisor and acknowledged by the		K 0€	69 K	 On July 12, 2013 maintenance direct mounted an 8" stainless steel divider plate on left side of gas cooking stove separational cooking stove from deep fryer. Facility kitchen only has one cooking stower and one deep fryer. No other divider plater needed. On July 9, 2013 maintenance director winserviced by administrator on mountian 8" stainless steel divider plate on his ide of gas cooking stove separational cooking stove from deep fryer. An audit to ensure 8" stainless steel divided plate is properly mounted and located a cooking stove will be conducted month for three months and/or until 100° compliance. The results of the audits will be compliance. 		late ing ove stes vas ing left ing der	

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